DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/15/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00		(X3) DATE SURVEY COMPLETED			
	155666		B. WING		<u> </u>	06/02/2011		
NAME OF PROVIDER OR SUPPLIER  WESLEY HEALTHCARE			_	STREET ADDRESS, CITY, STATE, ZIP CODE  1751 WESLEY ROAD  AUBURN, IN46706				
(X4) ID PREFIX TAG F0000	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	Complaint Number Complaint Number unsubstantiated of Unrelated deficies Survey dates: Jun Facility number: Provider number Aim number: 100 Survey team: Ann Armey, RN, Ellen Ruppel, RN Census bed type: SNF/NF: 42 Total: 42 Census payor type Medicare: 5 Medicaid: 30 Other: 7 Total: 42 Sample: 5 This deficiency a findings cited in	per IN00090323 due to lack of evidence. ency is cited. ne 1, 2, 2011 000307 155666 0285660  TC N  also reflects state accordance with 410 IAC		0000	This plan of correction is prepared and executed becof the state and federal law require it. This plan of correshall not be deemed an admission to or agreement the survey allegations. Wes Healthcare Center maintains the alleged deficiencies do individually or collectively jeopardize the health and sa of our residents, nor are the such character so as to limit capability to render adequat care. Wesley Healthcare cer further maintains that the allegations set forth herin do substantiate or constitute substandard quality of care. Please accept the last date on the plan of correction as facilities credible allegation compliance. Wesley Healthcare cer compliance for F0282, as corrective action was taken immediately and this was for cause no actual harm.	with ley s that not afety y of t our re o not noted the of are	(X6) DATE	
LABORATOR	Y DIKECTOR'S OR PROV	'IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE		TITLE		(X6) DATE	

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: V4X011 Facility ID: 000307

STATEMENT OF DEFICIENCIES (X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00 COI		COMPL	COMPLETED	
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(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F0282	Quality review concentration Cathy Emswiller  The services provi	RN					
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  Based on observation, interviews and record review, the facility failed to ensure 1 of 4 licensed nurses followed facility policy and professional standards of practice in medication preparation and administration. (LPN #2). This deficit practice affected 8 residents whose medications were to be administered by LPN# 2 on 6/1/11. (Residents B, C, H, I, J, K, L and M).  Findings include:  The clinical record of ventilator dependent Resident C was reviewed, on 6/1/11 at 10:00 a.m. The Medication Administration Record (MAR) for June 2001, was		F0	282	1. Nurse was suspended X3 then terminated prior to the ethe suspension2. All Nurses in-serviced on Facility policy all medications are to be prepared and administered athe rights of med administrat and are to be administered with 1 of the med pass times. The are not to be "set up" or prepared administration. BON or designee to monitor nurses from to monitor nurses from procedure 1 x per week x 2 months, 2 x per month x 2 months, 1 x per month x 2 months. 4. QA to follow x 6 months	end of that is per ion vithin hey vared	06/03/2011

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		ULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
155666			A. BUI B. WIN			06/02/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					ESLEY ROAD		
WESLEY	'HEALTHCARE			AUBUR	RN, IN46706		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
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	reviewed for current medications at						
		d the initials of					
	LPN#2 indicat						
		or the entire 12 hour					
	shift had been						
		esident's 4:00 p.m.					
		ra 10 mg (a hormone),					
		ose of alprazolam .25					
	_	y), a 12 noon oral					
	· ·	in mouth care (an					
	_	:00 p.m., dose of					
	, · ·	20 mg (a central					
	· –	n stimulant), and the					
	_	of 200 cc of water for					
	the resident's g	gastrostomy tube.					
	~	narcotic sign out					
		ed the alprazolam had					
	been signed ou	-					
		Č					
	Review of add	litional MARS on the					
	medication car	rt being used by					
	LPN#2 indicat	ted 7 additional					
	residents' medications had been signed out for the 12 hour shift on						
	6/1/11. These included:						
	Resident B's 2	2:00 p.m., dose of					
	Elixophyllin (a	a bronchodilator), a					
	4:00 p.m., dose of Buspar (for						
	_	00 p.m., dose of					
						<u> </u>	

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	li '		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
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			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	2		1	ESLEY ROAD		
WESLEY	' HEALTHCARE			AUBUR	N, IN46706		
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	docusate stool softener, a 2:00 p.m.,						
		dol (pain medication)					
		n., dose of Provera.					
	1	,					
	Resident H's n	nedications of					
	Coumadin at 5	5:00 p.m., diltazem					
		re medication), and					
	` •	or hypertension)					
	scheduled for	4:00 p.m., were					
	signed as given.						
	238.000000000000000000000000000000000000						
	Resident I's m	edications of					
	Neurontin (an	anticonvulsant) and					
	Prostat (dietar	y supplement) for					
	,	re signed as given.					
	-						
	Resident J's 2:	00 p.m., iron					
	medication an	d 5:00 p.m.,					
	Coumadin (for	r blood thinning)					
	were signed.						
	Resident K's Neurontin for 2:00						
	p.m., was sign	ied.					
	Resident L's F	Ieparin (blood					
	thinner) was s	igned as having been					
	given at 4:00 p	p.m.					
	Resident M's	Clonazepam (an					

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li li		IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	(X3) DATE SURVEY  COMPLETED
155666		A. BUILDING		06/02/2011	
			B. WING	DDDECC OITY CTATE ZID CODE	00/02/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE ESLEY ROAD	
WESLEY	'HEALTHCARE			N, IN46706	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
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IAG		t) for 2:00 p.m., was	IAG		DATE
		.) 101 2.00 p.111., was			
	signed.				
	The Director o	of Nursing (DON)			
		N#2 at 10:10 a.m., on			
		eried her about all of			
	•	as for the 12 hour			
		ned as given. LPN			
		ne had pre-poured the			
		or the entire shift			
		ought she might get			
		the day. She opened			
	the top drawer	of the medication			
	cart and plastic	e medication cups			
	with various p	ills were observed in			
	the cups. The	cups had been			
	labeled with re	esident's initials. The			
	individual med	dications were not			
	identified. She	e indicated she had			
	also signed the	e MARs for all the			
	medications and signed out the				
		gs from the narcotic			
		of narcotics with the			
	DON, indicate	ed the count was			
		e afternoon doses			
		emoved from the			
	_	he locked narcotic			
	box.				

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155666			A. BUILDING B. WING			06/02/2011	
<u> </u>					ADDRESS, CITY, STATE, ZIP CODE		
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WESLEY	'HEALTHCARE			AUBUR	N, IN46706		
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		olicy, dated 4/26/10,					
		administration,					
		e DON on 6/1/11 at					
	1	dicated "Medications					
	_	et up' or prepared					
		ne the medication is					
	to be administ						
	The current, u	ndated pharmacy					
	policy from (n	ame of pharmacy					
	documented) e	entitled "Medication					
	Administration	n" was provided by					
	the DON, on 6	5/1/11 and indicated					
	in part: "Pre-p	ouring medications					
	is not permitte	d." It also					
	indicated, "It i	s recommended that					
	medication be	charted immediately					
	after administr	ration, but if facility					
	policy permits	, medication may be					
	charted immed	liately before					
	administration."						
	During intervi	ew on 6/1/11 at 12:00					
	noon, the DON indicated the pre-poured medications had been						
	destroyed and	the policy for					
	dispensing and	d signing would be					
	followed for th	ne resident's whose					
	medications w	ere in LPN#2's					
						<u> </u>	

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medication cart.		*			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	NE	
	TAG			TAG	DEFICIENCY)	DATE	
3.1-35(g)(2)		medication ca	rt.				
3.1-35(g)(2)							
3.1-33(g)(2)		2.1.25(~)(2)					
		3.1-33(g)(2)					